Greensboro
Accident & Injury
Chiropractic

Welcome to the office of David R. Gibson, DC, DAAPM, DAAMLP.

Comprehensive and thorough care to address all of your injuries is our only concern.

Please take your time to carefully fill out all the questions on the following forms. Your answers enable us to provide the best treatment and decisions related to your recovery.

David Gibson, DC, DAAPM, DAAMLP

Greensboro Accident & Injury Chiropractic

AUTOMOBILE ACCIDENT HISTORY

Today's Date: ____

Patients Name: _____ Age: _____ DOB: _____ M____F____

Address _____ City: _____ State_____ Zip: _____

SS#: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____ Address: _____

Name of Spouse: _____ SS#: _____ DOB: _____

Name of your Auto Ins. Company: _____ Phone # : _____

Attorney Name : _____ Phone #: _____

Personal Health Ins.Com: _____ Policy/Group #: _____

NATURE OF ACCIDENT: **1.** Date of Accident: _____ Time of Day: _____

2. Were you: ( ) Driver ( ) Front Seat Passenger ( ) Left Back Seat Passngr ( ) Right Back Seat Psngr

3. Number of people in vehicle? _____ Were they injured? _____

4. Your Vehicle Type: ( ) Small Car ( ) Med Car ( ) Large Car ( ) Minivan ( ) Truck ( ) SUV

5. Road Material: ( ) Concrete ( ) Pavement ( ) Gravel ( ) Dirt

6. Road Condition: ( ) Dry ( ) Wet ( ) Damp ( ) Snow ( ) Icy ( ) Other _____

7. Conditions at Time of Accident: ( ) Dawn ( ) Daylight ( ) Dusk ( ) Night

8. Was visibility: ( ) Clear ( ) Misty ( ) Rainy ( ) Foggy

9. Were you wearing a seatbelt? _____ Does the vehicle have a head rest?_____

10. Were you aware of the approaching collision? ( ) Yes ( ) No

11. Did you brace for impact? ( ) Yes ( ) No

12. Just before impact your head was: ( ) Straight ( ) Turned Left ( ) Turned Right

A. Was your body positioned: ( ) Straight ( ) Rotated Left ( ) Rotated Right

13. Were you struck from: ( ) Behind ( ) Front ( ) Left ( ) Right

14. Just before impact your vehicle was: ( ) Stopped ( ) Slowing ( ) Speeding Up ( ) Proceeding Along ( ) Proceeding Straight Thru Intersection ( ) Turning Left ( ) Turning Right

Brief Description **(office use only)**

_____

_____

_____

_____

15. Did any part of your body strike anything in the car (for example did you hit your head, arm, leg, or body against the dashboard, window, headrest, etc) ( ) Yes ( ) No ( ) Do not recall

Bodypart	Surface Impacted

16. Did an airbag discharge and strike against you? ( ) Yes ( ) No

17. Did you lose consciousness? ( ) Yes ( ) No

18. Were you ( )confused, ( )disoriented, ( )emotionally shaken afterward ? (Check all that apply)

19. Did you feel pain soon after the accident? ( ) Yes ( ) No
If Yes, where? (1)_____ (2)_____ (3)_____

(4)_____ (5)_____ (6)_____

20. Where did you go after the accident? ( ) Hospital ( ) Urgent Care ( ) Home
( ) Work

21. You were transported by: ( ) EMT ( ) Self ( ) Friend ( ) Family ( ) Police_

22. At the first health care facility: Date Treated _____/_____/_____

B. Were x-rays taken? _____

C. What treatment was given? _____

D. Were you prescribed medication? _____

E. What was the diagnosis? _____

F. What was recommended? _____

23. What were your symptoms the next day? (1)_____, (2)_____
(3)_____, (4)_____, (5)_____

24. What treatments have you received prior to your visit to this office?
List other doctors consulted since the accident:

#1 Doctor Name_____
X-rays? _____
Diagnosis _____
Treatment _____
_____
_____

#2 Doctor Name_____
X-rays? _____
Diagnosis _____
Treatment _____
_____
_____

( ) Physical Therapy

Have you had: ( ) MRI ( ) CT ( ) EMG ?

25. Have you been in any accidents prior to this accident? ( ) Yes ( ) No

A. If yes. When? _____
B. Type of accident? ( ) Auto ( ) Work ( ) Home
C. What injuries did you suffer?
_____
D. Where did you treat for these injuries?_____
E. Were all injuries resolved? _____

26. Did you have any physical complaints before the latest accident? ( ) Yes ( ) No

A. If yes, what were they? _____

27. What are your complaints or symptoms today?

Symptom	Constant Most of the Time Frequent Occasional Seldom	Dull Ache Burning Sharp Stabbing	Grade 0-10, Where 0=no pain, and 10=severe pain
1.			**1 2 3 4 5 6 7 8 9 10**
2.			**1 2 3 4 5 6 7 8 9 10**
3.			**1 2 3 4 5 6 7 8 9 10**
4.			**1 2 3 4 5 6 7 8 9 10**
5.			**1 2 3 4 5 6 7 8 9 10**
6.			**1 2 3 4 5 6 7 8 9 10**
7.			**1 2 3 4 5 6 7 8 9 10**
8.			**1 2 3 4 5 6 7 8 9 10**
9.			**1 2 3 4 5 6 7 8 9 10**
10.			**1 2 3 4 5 6 7 8 9 10**

28. Are any of the symptoms of your injuries (listed above) aggravated by any activities / functions related to : ( ) Job ( ) Home

Specifically : ( ) Sitting ( ) Standing ( ) Lifting ( ) Bending ( ) Kneeling
( ) Squatting ( ) Walking ( ) Turning your head

Check Any Movement Below that Makes Your Symptoms Worse

Movement	**Describe Location and Character of discomfort**
□ Turning Head/Neck	
□ Bending Head/Neck	
□ Twisting Back	
□ Bending Back	
□ Shoulder Movement	
□ Elbow Movement	
□ Wrist Movement	
□ Hand Movement	
□ Hip Movement	
□ Knee Movement	
□ Ankle Movement	
□ Foot Movement	
□ Other	

29. Describe the Physical Activity Associated with your job: _____

30. Do your symptoms decrease or prevent any activity? ( ) Yes ( ) No
If Yes, explain: _____

31. Has your sleep been affected by your injuries? ( ) Yes ( ) No
If yes, explain:_____

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Health Care Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whom ever he/she assistant to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patients employer.

Patient's Signature: _____
Parent or Guardian Signature: _____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: ☐ **I DENY having or have had any of the symptoms or problems listed below.**

☐ chills	☐ fatigue	☐ night sweats	☐ weight loss
☐ daytime drowsiness	☐ fever	☐ weight gain	

Eyes/Vision: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ blindness	☐ change in vision	☐ field cuts	☐ photophobia
☐ blurred vision	☐ double vision	☐ glaucoma	☐ tearing
☐ cataracts	☐ eye pain	☐ itching	☐ wear glasses/contacts

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ bleeding	☐ ear drainage	☐ hearing loss	☐ nosebleeds	☐ sore throat
☐ dentures	☐ ear pain	☐ history of head injury	☐ postnasal drip	☐ tinnitus (ringing in ears)
☐ difficulty swallowing	☐ fainting	☐ hoarseness	☐ rhinorrhea (runny nose)	☐ TMJ problems
☐ discharge	☐ frequent sore throats	☐ loss of sense of smell	☐ sinus infections	
☐ dizziness	☐ headaches	☐ nasal congestion	☐ snoring	

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ asthma	☐ coughing up blood	☐ sputum production
☐ cough	☐ shortness of breath	☐ wheezing

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ angina (chest pain or discomfort)	☐ high blood pressure	☐ shortness of breath with exertion or exercise
☐ chest pain	☐ low blood pressure	☐ swelling of legs
☐ claudication (leg pain/ache)	☐ orthopnea (difficulty breathing lying down)	☐ ulcers
☐ heart murmur	☐ palpitations	☐ varicose veins
☐ heart problems	☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)	

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ abdominal pain	☐ diarrhea	☐ indigestion	☐ abnormal stool caliber	☐ vomiting blood
☐ belching	☐ difficulty swallowing	☐ jaundice	☐ abnormal stool color	
☐ black - tarry stools	☐ heartburn	☐ nausea	☐ abnormal stool consistency	
☐ constipation	☐ hemorrhoids	☐ rectal bleeding	☐ vomiting	

Female: ☐ **I DENY having any of the symptoms/problems and/or using any of the items listed below.**

☐ birth control	☐ cramps	☐ irregular menstruation	☐ vaginal bleeding
☐ breast lumps/pain	☐ frequent urination	☐ pregnancy	☐ vaginal discharge
☐ burning urination	☐ hormone therapy	☐ urine retention	

Male: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ burning urination	☐ frequent urination	☐ prostate problems
☐ erectile dysfunction	☐ hesitancy/ dribbling	☐ urine retention

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **cold intolerance**	☐ **excessive hunger**	☐ **goiter**	☐ **unusual hair growth**
☐ **diabetes**	☐ **excessive thirst**	☐ **hair loss**	☐ **voice changes**
☐ **excessive appetite**	☐ **abnormal frequency of urination**	☐ **heat intolerance**	

Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **changes in nail texture**	☐ **hair loss**	☐ **itching**	☐ **skin lesions / ulcers**
☐ **changes in skin color**	☐ **hives**	☐ **paresthesias**	☐ **varicosities**
☐ **hair growth**	☐ **history of skin disorders**	☐ **rash**	

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **dizziness**	☐ **limb weakness**	☐ **numbness**	☐ **slurred speech**	☐ **tremor**
☐ **facial weakness**	☐ **loss of consciousness**	☐ **seizures**	☐ **stress**	☐ **unsteadiness of gait/ loss of balance**
☐ **headache**	☐ **loss of memory**	☐ **sleep disturbance**	☐ **strokes**	

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **anhedonia**	☐ **behavioral change**	☐ **convulsions**	☐ **memory loss**
☐ **anxiety**	☐ **bi-polar disorder**	☐ **depression**	☐ **mood change**
☐ **loss or change in appetite**	☐ **confusion**	☐ **insomnia**	

Allergy: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **anaphalaxis**	☐ **itching**	☐ **chronic nasal congestion**	☐ **sneezing**
☐ **food intolerance**	☐ **acute nasal congestion**	☐ **rash**	

Hematologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **anemia**	☐ **blood clotting**	☐ **bruising easily**	☐ **lymph node swelling**
☐ **bleeding**	☐ **blood transfusion**	☐ **fatigue**	

PAST HEALTH HISTORY – **Fill out carefully as these problems can affect your overall course of care.**

Previous Care for Same Condition: ☐ **I have not seen a doctor for this condition OR Fill in the information BELOW**

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) _____

Type of Treatment: _____ Was the treatment beneficial in resolving condition? ☐ Yes ☐ No

Explain: _____

Previous Chiropractic Care: ☐ **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- ☐ ADD
- ☐ atopic dermatitis (eczema)
- ☐ allergies/hayfever
- ☐ anemia
- ☐ asthma
- ☐ bedwetting
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ depression
- ☐ diabetes
- ☐ ear infections
- ☐ fetal drug exposure
- ☐ food allergies (list below)
- ☐ headaches
- ☐ hepatitis
- ☐ HIV
- ☐ measles
- ☐ mumps
- ☐ psoriasis
- ☐ rash
- ☐ scoliosis
- ☐ seizure disorder
- ☐ sickle cell anemia
- ☐ spina bifida
- ☐ other:

Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.

- ☐ ADD
- ☐ alzheimers
- ☐ anemia
- ☐ arthritis
- ☐ asthma
- ☐ cancer
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ CRPS (RSD)
- ☐ CVA (stroke)
- ☐ cystic kidney disease
- ☐ depression
- ☐ diabetes (insulin dep)
- ☐ diabetes (non insulin)
- ☐ eczema
- ☐ emphysema
- ☐ eye problems
- ☐ fibromyalgia
- ☐ heart disease
- ☐ hepatitis
- ☐ HIV
- ☐ hypertension
- ☐ influenzal pneumonia
- ☐ liver disease
- ☐ lung disease
- ☐ lupus erythema (discoid)
- ☐ lupus erythema (systemic)
- ☐ multiple sclerosis
- ☐ parkinson's disease
- ☐ unspecified pleural effusion
- ☐ pneumonia
- ☐ psoriasis
- ☐ psychiatric problems
- ☐ scoliosis
- ☐ seizures
- ☐ shingles
- ☐ past history of similar symptoms
- ☐ STD's (unspecified)
- ☐ suicide attempt(s)
- ☐ thyroid problems
- ☐ vertigo
- ☐ other:

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? ☐ yes or ☐ no.

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- ☐ angioplasty
- ☐ appendectomy
- ☐ caesarian section
- ☐ cardiac catheterization
- ☐ carpal tunnel repair
- ☐ coronary artery bypass
- ☐ cosmetic
- ☐ D & C
- ☐ dental surgery
- ☐ gall bladder
- ☐ hemorrhoidectomy
- ☐ hernia repair
- ☐ hysterectomy
- ☐ joint reconstruction
- ☐ joint replacement
- ☐ knee repair
- ☐ laminectomy
- ☐ mastectomy
- ☐ pacemaker insertion
- ☐ rotator cuff
- ☐ spinal fusion
- ☐ tonsilectomy
- ☐ other:

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- ☐ back injury
- ☐ broken bones
- ☐ disability (ies)
- ☐ fall (severe)
- ☐ fracture
- ☐ head injury (loss of consciousness)
- ☐ head injury (no loss of consciousness)
- ☐ industrial accident
- ☐ joint injury
- ☐ laceration (severe)
- ☐ motor vehicle accident
- ☐ soft tissue injury (mild)
- ☐ soft tissue injury (moderate)
- ☐ soft tissue injury (severe)
- ☐ other:

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

general family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____

Social History

Alcohol: ☐ Never ☐ Social Consumption only ☐ Beer ☐ Liquor ☐ Wine ; _____ oz ____ glasses; ☐ Day ☐ Week ☐ Month

Drugs: ☐ Deny any illegal drug use ☐ Deny use of IV drugs ☐ Have not used drugs since _____ ☐ Have used drugs for _____

Tobacco: ☐ Deny Tobacco Use ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker ☐ Quit smoking
☐ Smoke; # _____ per ☐ Day ☐ Week ☐ Month ☐ Chew; #_____cans per ☐ Day ☐ Week ☐ Year

Do you exercise? No Rare Infrequently Occasionally Frequently Regularly

Pregnant ( ) Y ( ) N

Have you been diagnosed with: ( ) scoliosis, ( ) arthritis, ( ) joint degeneration, ( ) disc bulge/herniation

List Any Surgeries That You Have Had:

Surgery Type	Date of Surgery

Do you have a family physician ? ( ) Yes ( ) No

What is the physician name? _____

Please list any medical specialists that you see:

Specialist Type	Name

Your family physician will be provided treatment notes for your records.

Patient Signature / Date: _____ / _____

Doctor's Signature: _____ / _____

Assignment, Lien and Authorization
Insurance Benefits and Attorney

To Whom It May Concern:

I hereby authorize and direct you, the insurance company and /or my attorney, to pay directly to Greensboro Accident & Injury Chiropractic such sums as may be due and owing this office for services rendered me, both by reason of accident of illness, and by reason of any other bills that are due to this office, and to withhold such sums from any disability benefits, medical payment benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to the reimburse me or from settlement, Judgment or verdict on my behalf as may be necessary to adequately protect said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned office be given power of Attorney to endorse / sign my name on any and all checks for payment of my doctor bill.

I further understand and agree, that if this office must take any action to collect an outstanding balance on my account. I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees. This is regulated by NCGS 44-49 and NCGS 44-50.

Patient: _____ Date: _____

Witness: _____ Date : _____

Greensboro Accident & Injury Chiropractic

Authorization For Release

I, _____ authorize release of

- **Treatment notes**
- **X-ray Report of Findings**
- **CT Scan Report of Findings**
- **MRI Report of Findings**
- **Other _____**

From: _____
_____ **Phone: _____**
_____ **Fax: _____**
_____
_____

To:

Greensboro Accident & Injury
526 North Elam Avenue, #101 **Phone: 336-274-2520**
Greensboro, NC 27403 **Fax: 336-274-2528**

Patient Signature: _____ Date: _____

Print Name: _____

DOB: _____ /_____ / _____